CFS 399-1
Rev. 04/2010

State of Illinois
Department of Children and Family Services

Office of Clinical Practice and Field Support
CLINICAL REFERRAL FORM

Instructions: ***Submit the completed CFS 399-1 Clinical Referral Form via Outlook to ClinicalRef or Fax to (800) 733-3308. All questions should be directed to (866) 225-1431.***

DATE:	

Minor(s) ***(Last Name, First Name)*****:**	**DOB/Age:**
ID# or SCR#:	**R/S/F:**
Case Name ***(Family Name)*****:**	
Referral Source: ***(Person making referral)***	**Telephone:** **Fax:**
Source Unit: ***(Unit making referral)***	☐ **Court** ☐ **DCP** ☐ **GAL** ☐ **Intact** ☐ **Placement** ☐ **Public Defender** ☐ **Other** _____
Caseworker's Name: ***(If different than person making referral)***	**Telephone:** **Fax:**
Supervisor's Name:	**Telephone:** **Fax:**
Legal Information:	**Next Court Date:** _____ **Purpose:** _____ **Courtroom:** _____ **DCFS Legal Attorney:** _____
Has this case been staffed internally by your agency's clinical staff?	☐ **Yes** ☐ **No** **If Yes, Date of Staffing:** _____

CHECK RELEVANT TOPICS

- ☐ **(A) Child Sexual Abuse & Victimization**
- ☐ **(B) Developmental Disability**
- ☐ **(C) Hearing Impairment**
- ☐ **(D) Domestic Violence**
- ☐ **(E) Caregiver with Chronic Illness**
- ☐ **(F) Older Caregiver Assessment**
- ☐ **(G) Lesbian, Gay, Bisexual, Transgender & Questioning Youth**
- ☐ **(H) Permanency & Placement Issues**
- ☐ **(I) Psychiatric Lockout**
- ☐ **(J) Adult Mental Health**
- ☐ **(K) Child Mental Health**
  - ☐ **Age 10 or under with Mental Health**
- ☐ **(L) Child Substance Abuse**
- ☐ **(M) Adult Substance Abuse**
- ☐ **(N) Life Threatening Blood Disease**
- ☐ **(O) Indian Native American**
- ☐ **(P) Help Unit (☐ POS/☐ DCFS)**
- ☐ **(Q) Request for field Teacher support**
- ☐ **(ZZ) Other** ***(explain)***

_____

List Date & Time of Availability:

_____
_____
_____
_____
_____

NARRATIVE:

Please provide: ***(The narrative box expands when completing this form on the computer.)***

1. **What issues would you like the clinical unit to address?**

   _____

2. **Provide a detailed summary of all clinical issues:**

   _____

3. **Provide the names and contact information of significant people that should be part of the staffing including the name of the parent(s) & their attorney (contact information):**

   _____

4. **For DCP referrals, provide available DCP and collateral records (attach documentation to this form):**

   _____

(DO NOT COMPLETE - For Clinical Use Only)

Minor(s) *(Last Name, First Name)*:	**DOB/Age:**
ID# or SCR#:	**R/S/F:**

CLINICAL SUPERVISOR APPROVAL:

Signature: _____ *OR* Verbal Approval Given: ☐

Name of Supervisor: _____

Clinician Assigned: _____

Date Assigned: _____

ASSESSMENT OF CLINICAL SERVICES NEEDED: *Only Check One*

☐ **2—Staffing (DCFS)**	☐ **9—Post Adopt**
☐ **3—Staffing (POS)**	☐ **10—Lockout (Psych. Hospital)**
☐ **4—Psych (DCFS)**	☐ **11—Parent(s) with Mental Illness**
☐ **5—Psych (POS)**	☐ **12—Not appropriate *(See comments section below)***
☐ **6—Consult (DCFS)**	☐ **13—Critical Events Staffing**
☐ **7—Consult (POS)**	☐ **99—Other *(explain)* _____**

COMMENTS, INSTRUCTIONS TO CSC OR DISPOSITION OF CONSULTATION:

_____